JAMES H. "JIM" BROWN
COMMISSIONER OF INSURANCE
STATE OF LOUISIANA

P.O. Box 94214
BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900
FAX (225) 342-3078
http://wwwldi.ldi.state.la.us

October 9, 2001

DIRECTIVE NUMBER 01 – 158

Exclusions

TO: ALL HEALTH INSURANCE ISSUERS OFFERING INDIVIDUAL HEALTH INSURANCE COVERAGE

PURPOSE

It has been brought to my attention that a clarification is needed regarding proper compliance with and guidance under Louisiana Revised Statutes (LA-R.S.) Title 22, Section 250.11, that provides for individual health insurance coverage to exclude coverage for specific preexisting medical conditions for periods longer than twelve months following the effective date of an individual person's coverage. The purpose of this directive is to clarify regulatory issues for those policies that fall under the individual market as defined in LA-R.S. 22:250.1 (5) (m). The following is intended to address those issues that have been made known to the Department of Insurance, and is not meant to limit the scope of the Department's regulatory authority over any insurance activity that may not be addressed in this directive.

REGULATORY ISSUES

A. Is there a maximum time period for the exclusions?

B. How specific must the exclusion be in reference to the medical condition to be excluded?

C. Can an insurer/HMO exclude certain benefits if an individual has full or partial creditable coverage?

D. How should notice be given to policyholders?

DISCUSSION

Is there a maximum time period for the exclusions?

Section C of R.S. 22:250.11 provides in part, "Notwithstanding the provisions of Subsections B and D of this Section, individual health insurance coverage offered to any individual may exclude coverage for medical care for specific medical conditions that existed prior to the issuance of coverage, subject to the following conditions:

> (2) The exclusion of coverage for medical care shall be for a specified period of time longer than twelve months and shall cover a specific medical condition.

The Department takes the position that as long as the period is longer than twelve months and is specified in the rider, then there is no maximum time period for the exclusion. Policies need to state specifically what the period will be for the exclusion (1, 2, 5 years, etc.).

Section C (5) further provides that offers of coverage shall not include more than **two specific medical conditions** being excluded from coverage per individual covered under the policy or subscriber agreement. With respect to the time periods, there can be two different time periods for the two exclusions (exclusion one – 5 year exclusion, exclusion two – 2 year exclusion, etc.).

How specific must the exclusion be in reference to the medical condition to be excluded?

Section C (3) provides the following: "Before or at the time of issuance of the policy or subscriber agreement, the health insurance issuer shall provide the applicant with a written notice explaining the exclusion of coverage for the specific medical condition. Such exclusion of coverage shall not be applied to any other medical condition **not arising directly as the result of the specific medical condition being excluded.** (emphasis added)

The Department recognizes the language emphasized as a more stringent measure for determining how specific the exclusion must be in reference to the medical condition. The International Classification of Diseases Clinical Modification Code, as well as Stedman's Medical Dictionary, both provide helpful guidelines that should be referenced in labeling the specific medical conditions excluded in the policies.

Ex. Exclusion for asthma
- A subsequent diagnosis of viral pneumonia and an attempt to exclude coverage for this type of pneumonia may be impermissible as the viral pneumonia is a condition that might not arise directly from the asthma.

Ex. Exclusion for the female reproductive organs
- This exclusion would be improper, in that the organs are not a specific medical condition.

Exclusion of coverage for medical care also shall not apply to any services, benefits, or options mandated by state or federal law to be included in a policy or certificate of coverage.

Ex. Diabetes Mandate
- LA-R.S. 22:215.21 provides coverage for the equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a physician, or, if applicable, the patient's primary physician.

- It is permissible to exclude a specific medical condition that is not covered by the mandate (ex. diabetic retinopathy).

Can an insurer/HMO exclude certain benefits if an individual has full or partial creditable coverage?

Even if a person has full or partial coverage, in lieu of declining an application, issuers may offer coverage with an exclusion for specified medical condition(s).

Moreover, when a person decides to move to another company, whether or not they are portable, if their existing coverage contains an exclusion, the subsequent issuer may include the same exclusion and duration or write their own exclusion and durations.

How should notice be given to policyholders?

Section C (4) provides, "The offer of coverage shall state that the applicant is receiving coverage with an exclusion of coverage for a specific medical condition. Such statement shall be printed in bold print as a separate section of the policy or subscriber agreement or on a separate form".

Along with the requirements above, the Department advises issuers of these policies to comply with the following requirements for policy forms. A signature line should be provided for applicants to sign the rider/policy such as the following example:

I hereby represent and agree that this exclusionary rider shall be considered as a part of my contract and/or original application.

_____
Signature Of Applicant

_____
Witness

_____
Date

Exclusionary rider forms should also state in writing the specified time period of the exclusions followed by the provisions found in Section C (7), which states the following:

> The health insurance issuer shall agree to review the underwriting basis for the exclusion from coverage upon written request by the insured no more often than once in a twelve-month period. The issuer shall remove the exclusion, effective upon renewal, if the insurer determines that the evidence of insurability is satisfactory.

Please be guided accordingly.

BY: 
J. ROBERT WOOLEY
ACTING COMMISIONER OF INSURANCE